

TUBERCULOSIS SUSPECT CASE REPORT

PATIENT _____ REPORTED BY: _____
 Last First MI Phone (____)
 ADDRESS _____ Diagnosing Facility _____
 _____ Medical Record# _____
 PHONE (____) _____ Patient hospitalized at diagnosis? ☐ Yes ☐ No
 BIRTH DATE: ____/____/____ Sex ☐ M ☐ F Patient currently hospitalized? ☐ Yes ☐ No
 Social Security Number: _____ Treating Physician: _____
 IF PATIENT UNDER 18, PARENT NAME/DOB: _____ Address _____

 EMPLOYER/SCHOOL: _____ Phone (____) _____
 INSURANCE/FUNDING: _____ Referred to for F/U: _____ MD
☐ White, non-Hispanic ☐ Black ☐ AM Ind/Eskimo Address _____
☐ Hispanic ☐ Asian/Pac. Is. (specify) _____
☐ Other _____ Phone (____) _____

Will MD be continuing care? ☐ Yes ☐ No

☐ Pulmonary TB ☐ Extrapulmonary (site) _____ Date dx: ____/____/____
 Skin Test _____ mm ☐ Negative Chest X-Ray Date: _____ ☐ Cavitory ☐ Non-Cav.
 Date read _____ ☐ Not done Impression: _____
☐ Anergic Controls: _____

If Pulmonary, check symptoms:

☐ Cough ☐ Night sweats
☐ Sputum production ☐ Hemoptysis
☐ Weight loss (# of lbs.) _____

History of TB Treatment ☐ Yes ☐ No

If Yes: Where/when treated?

If asymptomatic, reason for evaluation

Other medical conditions relevant to diagnosis

HIV Status: ☐ Positive ☐ Negative ☐ Unknown Patient's current weight

Date: _____ ☐ Recommended ☐ Pending Psychosocial History?

CD4 Count _____ Date: _____ Allergies

SPECIMEN NUMBER	SPECIME DATE	SPECIMEN TYPE	AFB SMEAR	AFB CULTURE

MEDICATIONS	DOSE	START DATE
ISONIAZID		
RIFAMPIN		
ETHAMBUTOL		
PYRAZINAMIDE		
PYRIDOXINE (B6)		

Lab Name/Acct. No.

Is Directly Observed Therapy (DOT) indicated? ☐ Yes ☐ No; Reason:

Additional Comments:

_____Date

Reported: _____Recorded By:

TUBERCULOSIS CONTROL

Reporting of all patients with confirmed or suspect tuberculosis (TB) is mandated by state Health and Safety Codes Div. 4, Chapter 5 and Admin, Codes, Title 17, Chapter 4, Section 2500 and must be done within **one day of diagnosis**.

WHY DO YOU REPORT?

Because it is the law! The health department performs many vital functions to ensure public health and safety, including case management, contact follow-up, assessment of compliance with treatment and appointments, and directly observed therapy (DOT). The TB Control staff will also assist in facilitating timely and appropriate discharge planning. **Since January 1, 1994, state law mandates that all TB patients have a health department-approved discharge plan, *prior* to discharge.**

WHO MUST REPORT?

Anyone aware of a patient suspected to have, or confirmed with, active TB.

WHEN DO YOU REPORT?

- A) When active TB is one of the primary differential diagnoses. This often occurs when:
 - 1. signs and symptoms of TB are present, and/or
 - 2. the patient has an abnormal chest x-ray consistent with TB, and/or
 - 3. the patient is placed on multidrug therapy for active TB or
- B) When specimen smears are positive for acid fast bacilli (AFB).
- C) When the patient has a positive *M. tuberculosis* or *M. bovis* culture.

HOW DO YOU REPORT?

The form on the other side is to be completed **in its entirety** and submitted to the health department. TB Control staff will review this form and may return a call to the physician as needed.

By phone: 692-8610

By pager: 526-1878 (weekdays 8:00 a.m.-5:00 p.m., weekends/holidays 8:00 a.m.-5:00 p.m.)

By FAX: 692-5516

This form, when submitted to TB Control, fulfills the legal requirement for reporting. The process for discharge or transfer approval necessitates a different form. Please call 692-8610 for further information about discharge care plan submission/approval.